Table 4
Certificates and prescriptions (age 15–44 only)

	Total no. of consultations	*Percentage with certificate*	*Percentage with prescription*
English:			
Male	1,810	33	54
Female	2,733	14	56
Irish:			
Male	873	36	49
Female	390	17	51
West Indian:			
Male	721	41	49
Female	1,307	27	48
West African:			
Male	308	30	51
Female	339	19	51

Incidentally, it is interesting to see how, at every age, the women consult more than the men. They also have more house calls (Table 2). From infancy through adulthood to the years after retirement the female of the species, English or immigrant, is visited by her doctor more frequently than the male.

But looking at an average consultation rate can be very misleading. We also need to know something about the two extremes: the patients who never consult us and the patients who come more than twice the average. (For convenience we chose to count those who consult us more than ten times in the twelve months.) We also looked at these figures in respect of two distinct groups: patients who were on the list all the year and patients who registered during the twelve months. Patients who newly register usually (though, of course, not always) do so because something is the matter with them or one of their family and they need attention (Table 3).

The proportion of English patients who did not consult at all was midway between the proportion of Irish and of West Indians, and this applied to both the 'all year' and newly registered groups. The largest proportion of frequent attenders was to be found amongst the West Africans (both sexes).

What about paper work in the form of certificates and prescriptions (Table 4)? We found that we issued prescriptions at less of the consultations we had with immigrants than we did with English patients, but we issued certificates more often. With regard to the high proportion of West Indian women taking certificates it should be remembered that a far higher number of them go out to work than English women.

Table 5
Type of certificate (males 15–44 only)

	Total no. of consultations	*Percentage with certificate*			
		Private	*NHS first*	*NHS intermediate*	*NHS final*
English	1,810	18	10	7	9
Irish	873	26	9	9	7
West Indian	721	27	11	11	10
West African	308	15	10	4	9

We looked more closely at the certificates we issued for the men in the 15–44 age group (Table 5). West Indians had proportionately more onset-commencement NHI certificates, and the Irish proportionately less than the English. The West Indians also had more mid-episode certificates than the English, as did the Irish. It does seem that, whatever the reason, West Indian men stay away from work for medical reasons more often and stay away longer.

All patients at the health centre are seen by appointment. By and large, immigrants are as good at keeping appointments as English patients (Carne 1967).

REFERENCES
Carne S
(1961) *Brit. med. J.* ii, 1556
(1967) *Brit. med. J.* iv, 544
(1969) In: Human Relations in General Practice. Ed. J McKenzie. London; p 33
Oakley R (1968) New backgrounds. London

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Immigrants and Emotional Stress

Anxiety caused by inability to adapt oneself in the host community invariably complicates and exaggerates physical illness. The patient may first present himself with aches and pains, hypochondriasis and psychosomatic diseases, or he may show other signs of anxiety and neuroses.

The modern concept of all treatment, not just psychiatric treatment, is a three-dimensional approach with an attempt to deal with physical, social and psychological aspects in any given case. In addition to that it is also essential when working with immigrants to understand the cultural and displacement factors.

The form of mental illness would be the same, whatever the culture. It can be organic or functional, both of which may be acute, sub-acute or chronic. Functional forms can be psychotic, neurotic or psychopathic personality disorders. But the content of mental illness depends on

cultural and environmental factors and largely determines how the illness or complaints present themselves to the doctor. Schizophrenia for instance is a universal disease, found all over the world, but the content of a patient's hallucinations or delusions on his background and his own method of explaining his paranoia or hallucinations, i.e. the types of voices that he can hear – witchcraft, electricity, religious punishment or contact with the supernatural.

When one gets depressed one is likely to lose confidence in oneself and the order of priority is that one loses confidence first in the things one is most proud of. In the East and in the Pakistani patriarchal society, father is the dominant figure in the home and there is a great deal of mystique about manhood and sexual potency. When a Pakistani starts becoming ill, he often goes to the doctor, complaining of sexual weakness, nocturnal emissions, which he says are responsible for the weakness in his body.

In the West Indies the concept of manliness is related to physical strength and perhaps that might explain why many West Indians present themselves complaining of aches and pains in the body, strange sensations in the head and inability to go to work. Similarly the content of an Irishman's thought disorder is often likely to be related to religious ideas.

The answer to the question why people present their problems in the way they do probably lies in their cultural background, and their social and religious upbringing. To ignore the culture from which the patient comes and its understanding would make it virtually impossible to understand the psycho-pathology of the related suffering.

It has been suggested that behavioural disorders are related to technological development and the rate of social change, and certain other factors, such as how freely people mix in a particular society, the description and frustrations of the basic tendencies and the characteristics of early mother-child relationships. Conversion hysteria for instance, a phenomena frequently noted in the past, is nowadays seen more often in the underdeveloped countries and among the economically weaker classes.

This subject is a separate study by itself and is also being followed up in Birmingham with particular reference to immigrants. Our Birmingham study covered admissions to four major hospitals with a view to studying the various differences in the presentation and management of psychiatric cases and five major racial groups, Indians, Pakistanis, West Indians, Irish and a control group of British-born, living in slum areas. In this study the incidence of mental illness among all immigrants was shown to be in the region of 8 to 9 per thousand of population, as compared to the incidence among British-born of 6·14 (the national overall figure being 3–4 per thousand.)

One might perhaps talk of a 'displaced person's syndrome', that is the difficulty of being away from home, work, loneliness, accommodation, &c., the sort of problems faced by people at the end of the 1939–45 war. The present immigrants have also to deal with further stresses of colour prejudice, language barrier, climate, a change of habits and food and of religious conflict in their minds.

The present generation of immigrants in Britain has come here because of the economic pull of industrial Britain, and of course of their own free will. They are therefore willing to compromise part of their feelings in order not to jeopardize their jobs and their stay in this country. They do not really wish to become Anglicized and do want to maintain their culture, religion and heritage. They are willing to accept many of the difficulties of life in Britain.

But the next generation of coloured children would look at things entirely differently. The ones who were born here or came to Britain when they were very young are, except for their colour, British and have never known another country. Their efforts to find an identity and to be accepted in the host society can at times result in considerable unhappiness and frustration.

In schoolchildren this can show in various forms of anxiety states and psychiatrists are already becoming familiar with cases of school phobia, nailbiting, nightmares and bedwetting, &c., among these coloured children. There is evidence of increasing incidence of delinquency among coloured children, particularly of non-Asian origin. The discipline and pride of heritage in the Asian homes and their close-knit family life are no doubt responsible for less delinquency among them. How long these influences will last, one does not know.

Immigration causes considerable stress, and in dealing with the problems arising from it and the consequent struggle there are bound to be casualties in the form of psychological or even physical breakdown. The need for understanding the problems behind such a breakdown by understanding the culture cannot be too strongly emphasized.